



Application for Benefits

Questions and Answers

If you need help reading this, please ask the receptionist for help.

Q. How do I apply for benefits?

A. It's easy - just fill out the application. Check the box on the top of page 2 if you need help completing this form. The date you apply affects how soon your benefits start. If you are applying for someone else, complete the questions with that person's information. **We need at least your name, address, and signature on page 2 to start the application process and pages 3 and 4 to complete the application process. If you don't have an address, please talk to the receptionist when you turn in your application so we can find out how to contact you.** You can turn the form in to the receptionist or mail it to your local Community Services Office (CSO). For long-term care services, mail the form to your local Home and Community Services Office. You will not need an interview if you are applying for medical only.

Q. When will my benefits begin?

A. If you are eligible for cash assistance, your benefits start on the date we get all the information to decide you are eligible. If you are eligible for food benefits, the amount of your benefits is usually based on the date we get the application. For medical, the date your coverage begins depends on which medical program you qualify for and the date we get your application. You may ask for help with some past medical bills.

Q. What if I need food assistance right away?

A. In addition to giving us your name, address, and signature, **check the box for Basic Food assistance in Number 9, answer Questions 10 through 14,** and take it to the receptionist now. If you are not in the local office, you may mail this application or bring it into the local office.

You may get food assistance within five (5) days from the date we get your application if:

- You show proof of your identity; **and**
- Your household has very little income or resources; **or**
- Your household's income and resources are not enough to cover your monthly rent and utilities combined; **or**
- Your household includes a destitute migrant or seasonal farm worker.

Important Information about Immigration Status and Social Security Numbers

- You can apply for benefits for part of your family even if some family members may be ineligible because of immigration status. Washington State has some medical programs for people without Social Security Numbers or proof of immigration status.
- If you need cash or food assistance, you need to provide Social Security numbers or immigration status only for people who are applying. You may still provide your Social Security number voluntarily and we will use it only to verify needed information to determine eligibility, such as your income. If you choose not to provide your Social Security number or immigration status, your income and resources must still be verified if needed to determine eligibility.

People Helping People



Cash Assistance



Food Assistance



Medical Assistance



General Assistance
for the
Unemployable



Nursing Home Care
or Assisted Living

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, sex, religion, national origin, or political beliefs. Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

APPLICATION FOR BENEFITS

☐ If you need help filling out this form,
please check this box and take it to the receptionist.

FOR OFFICE USE ONLY

DATE
RECEIVED

INITIALS

1. FIRST NAME	MIDDLE INITIAL	LAST NAME	SIGNATURE (REQUIRED)	
3. STREET ADDRESS WHERE YOU LIVE			CITY	STATE ZIP CODE
5. MAILING ADDRESS (IF DIFFERENT)			CITY	STATE ZIP CODE
9. I am applying for (check all that apply): <input type="checkbox"/> Cash <input type="checkbox"/> Nursing Home Care <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Drug and Alcohol Treatment <input type="checkbox"/> Basic Food Assistance <input type="checkbox"/> Assisted Living (COPES or In-Home Care) <input type="checkbox"/> Other (please list): _____				
10. How much will your income be this month: \$ _____				
11. How much money do you have in cash and bank accounts: \$ _____				
12. How much is your rent/mortgage: \$ _____				
13. Do you pay for utilities? <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. Is anyone in your household a seasonal or migrant farm worker? <input type="checkbox"/> Yes <input type="checkbox"/> No				

FOR OFFICE USE ONLY - Household eligible for expedited service: ☐ Yes ☐ No **Screener's Initials:** _____ **Date:** _____

15. I need a phone interview because I'm: ☐ Elderly ☐ Disabled ☐ Working ☐ Other hardship: _____

16. ☐ I need a translator. I speak: _____ or ☐ sign; I want my letters in: _____

13.If applying for food assistance, how many people in your household do you buy and prepare food for? _____

14. In the past 30 days, I got cash, food, or medical assistance from another state or source: ☐ Yes ☐ No

15. I or someone I'm applying for was convicted of a drug-related felony committed after 08/21/96: ☐ Yes ☐ No

16. I am or someone I'm applying for is fleeing from the law to avoid going to court or jail for a felony crime: ☐ Yes ☐ No

17. I or someone in my household have a (check all that apply): ☐ Pregnancy; due date: _____
☐ Medical emergency ☐ Eviction notice ☐ Utility shutoff or no heat
☐ Domestic violence situation ☐ Disability (list type): _____

18. The following information is voluntary and will not be used to determine your eligibility for benefits.
My ethnic background is Hispanic or Latino: ☐ Yes ☐ No I consider my race to be (check **all** that apply): ☐ White
☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native; tribe name: _____ ☐ Other (list): _____

19. List everyone in your household even if you are not applying for them (attach additional sheets, if necessary).

NAME (FIRST, MIDDLE, LAST)	HOW IS THIS PERSON RELATED TO YOU?	DO YOU WANT BENEFITS FOR THIS PERSON?		BIRTHDATE	OPTIONAL FOR NON-APPLICANTS			SEX M OR F	
		YES	NO		U.S. CITIZEN?	IF NOT A CITIZEN, IS THERE A DOCUMENT TO SHOW STATUS?	SOCIAL SECURITY NUMBER		
		YES	NO		YES	NO	YES	NO	
	Myself	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	CLIENT IDENTIFICATION NUMBER
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I. General Information

- Everyone I'm applying for lives in Washington State: ☐ Yes ☐ No If yes, since (list date): _____
- I am or someone in my household is a sponsored alien: ☐ Yes ☐ No
- Someone is temporarily out of my home: ☐ Yes ☐ No If yes, who (list): _____
- I am or someone in my household is a veteran or dependent or spouse of a veteran (living or deceased): ☐ Yes ☐ No
- I am living in: ☐ My own house or apartment ☐ Adult Family Home ☐ Group Home
☐ Facility (list type): _____ ☐ Other: _____
- I am: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

II. Medical and Health Insurance Information

I or we (check appropriate box):

- Have health problems that prevent me (us) from working ☐ Yes ☐ No
- Have unpaid medical bills ☐ Yes ☐ No
- Need help with unpaid medical bills for any of the past three (3) months ☐ Yes ☐ No
- Plan to enter, are in, or recently left a medical facility (such as a hospital or nursing home) ☐ Yes ☐ No
- Have health insurance (including Tricare or Long-Term Care Insurance) ☐ Yes ☐ No
- Have Medicare (NOTE: This is **not** the same as having medical coupons) ☐ Yes ☐ No
- Had an accident requiring medical care ☐ Yes ☐ No

III. Resources

You do not need to complete this section if you are applying for Children's Medical or Pregnancy Medical ONLY.

In addition to the items listed below, other examples of resources include cash, money held by others, sales contracts, livestock, crops, and business equipment.

- I, my spouse, or someone I'm applying for has resources: ☐ Yes ☐ No If yes, please list them below:

TYPE OF RESOURCE?	WHOSE RESOURCE IS IT?	WHERE IS THE RESOURCE?(E.G., NAME OF BANK)	AMOUNT OR VALUE	WHOSE RESOURCE IS IT?	WHERE IS THE RESOURCE?(E.G., NAME OF BANK)	AMOUNT OR VALUE
Checking account(s)			\$			\$
Savings or credit union account(s)			\$			\$
CD or money market account(s)			\$			\$
Trusts or annuities			\$			\$
Stocks, bonds, or mutual funds			\$			\$
Retirement fund or IRA			\$			\$
Burial funds, plans, or plots			\$			\$
Life insurance			\$			\$
Property			\$			\$
Other:			\$			\$
Other:			\$			\$

- I, my spouse, or someone I'm applying for has sold, traded, given away, or transferred a resource in the last five (5) years (includes transfers into trusts or life estates): ☐ Yes ☐ No If yes, what: _____ When: _____

- I have or someone I'm applying for has the following vehicles (including trucks, vans, boats, and trailers):

YEAR (E.G., 1980)	MAKE (E.G., FORD)	MODEL (E.G., ESCORT)	IS THIS VEHICLE LEASED?	I (WE) USE THIS VEHICLE FOR MEDICAL PURPOSES.	I (WE) STILL OWE ON THIS VEHICLE.
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. Income

1. I, my spouse, or someone I'm applying for has income: ☐ Yes ☐ No If yes, please complete this section:

EMPLOYER'S NAME AND PHONE NUMBER

GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE TAXES)

\$ _____ every: ☐ Hour ☐ Week ☐ Two weeks

Is this job self-employment? ☐ Yes ☐ No

☐ Twice a month ☐ Month Hours per week: _____

Who makes the income:

Pay dates (e.g., 1st and 15th, or every Friday): _____

EMPLOYER'S NAME AND PHONE NUMBER

GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE TAXES)

\$ _____ every: ☐ Hour ☐ Week ☐ Two weeks

Is this job self-employment? ☐ Yes ☐ No

☐ Twice a month ☐ Month Hours per week: _____

Who makes the income:

Pay dates (e.g., 1st and 15th, or every Friday): _____

2. I, my spouse, or someone I'm applying for quit a job within the past 60 days. ☐ Yes ☐ No

3. OTHER INCOME	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT
Unemployment benefits		\$		\$
Social Security		\$		\$
Supplemental Security Income (SSI)		\$		\$
Child support or spousal maintenance		\$		\$
Retirement or pension		\$		\$
Veterans Administration (VA) or military benefits		\$		\$
Labor and Industries (L&I) or insurance benefits		\$		\$
Trusts or annuities		\$		\$
Other:		\$		\$

V. Monthly Expenses

RENT	MORTGAGE	SPACE RENT	HOMEOWNER'S INSURANCE	PROPERTY TAXES	PROPERTY ASSESSMENTS
\$	\$	\$	\$	\$	\$

Utilities (check all that apply): ☐ Electricity (**not heat**) ☐ Phone ☐ Heating (gas, electric, oil) ☐ Water, sewer, garbage

Another person or agency helps me pay either all or part of my shelter costs: ☐ Yes ☐ No

If yes, who: _____ What expense: _____ Amount they pay: \$ _____

I (we) pay or are supposed to pay (check all that apply):

☐ Child care or dependent care Monthly amount: \$ Who pays:

☐ Child support Monthly amount: \$ Who pays:

☐ Medical bills Monthly amount: \$ Who pays:

DECLARATION AND SIGNATURE

I have read (or had explained to me) my rights and responsibilities and received a copy of the Client Rights and Responsibilities, DSHS 14-113(X). I must report changes as required by the department. I must provide proof I am eligible. DSHS may help me get the proof or contact other persons or agencies for it. By getting Temporary Assistance to Needy Families (TANF) or medical care benefits, I assign certain rights to child or medical care support to the State of Washington. I declare under penalty of perjury that the information I gave in this application is true, correct, and complete to the best of my knowledge. I understand that I can be criminally prosecuted if I incorrectly receive cash, food, or medical assistance because I have willfully made a false statement or willfully failed to report something I should report. Only the applicant must sign if applying for Food Assistance. If applying for cash or medical help, all adult household members must sign.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF OTHER ADULT APPLICANT	DATE
SIGNATURE OF HELPER OR REPRESENTATIVE	DATE	SIGNATURE OF WITNESS IF SIGNED WITH AN "X"	DATE